STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E132	A. BUILDING _____ B. WING _____	05/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST CONVALESCENT CENTER	450 COLLEGE ST NEWPORT, TN 37821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of facility policy, and medical redord review, the facility failed to ensure proper placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube prior to giving medications for one (A) of one resident with a PEG tube observed during medication pass; and failed to complete a thorough head-to-toe and skin assessment following a fall for one resident (#6) of fourteen residents reveiwed. The findings included: Observation during the medication pass on May 8, 2012, at 7:40 a.m., in resident A's room, revealed Registered Nurse (RN) #3, was preparing to administer medications to the resident. Further observation revealed the nurse poured water into the cup with the medications, placed the medications into the 60 cc (cubic centimeter) syringe, disconnected the continuous tube feedings, and administered the medications through the PEG tube, and failed to check for proper placement of the PEG tube prior to giving the medications. Interview with RN #3, on May 8, 2012, at 7:50 a.m., in the hallway outside the resident's room, confirmed the nurse did not check for the proper placement of the PEG tube prior to giving the	F 281	A 1:1 discussion regarding Administering Medications to Tube Fed Patients was conducted with Nurse #3 on May 8, 2012 by the Director of Nursing. All residents who require their medications to be administered per external route have the potential to be affected. • The Nursing Team Leader and Director of Nurses will conduct a mandatory 1:1 in-service for the licensed nurses in regard to policy 11-177 (Administering Medications to Tube Fed Patients). • The in-service will include review of the policy and all licensed nurses will be observed on procedure with return demonstration. • Random observations of licensed nurses will be done monthly and reported to the Quality Assurance Committee quarterly.	6/28/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 5/29/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 medications to the resident. Review of facility policy #11-177, Administering Medications to Tube Fed Patients, with a review date of August 21, 2011, revealed "...disconnect the feeding tube administration set or open Y port on the feeding tube...place stethoscope just below the xiphoid process and instill 10-25cc of air...listen for a gurgling or whooshing sound to confirm placement..." Interview with the Director of Nursing (DON), on May 8, 2012, at 10:50 a.m., in the conference room, confirmed the facility policy was not followed for medication administration through a PEG tube. Resident #6 was admitted to the facility on April 2, 2008, with diagnoses including Hypertension, Vascular Dementia with Depression, Alzheimer's Disease, Psychosis, and Senile Psychosis. Medical record review of the resident's Minimum Data Set (MDS) dated March 29, 2012, revealed the resident had short and long-term memory problems, had severely impaired cognition, required staff assistance for transfers and ambulation, and had not experienced any falls. Review of the resident's Care Plan, dated October 21, 2011, revealed the resident was at risk for falls. Continued review of the Care Plan revealed, "If (resident) falls, Assess from Head to Toe Incl (including): VS (vital signs), Neuro (neurological) Status, ROM (Range of motion), Skin Assess (assessment), Musc/Skel (musculoskeletal) Assess, and Pain initially then	F 281		

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F 281	Continued From page 2 q (every) 8H (hours) x (for) 48H..." Medical record review of a nurse's note dated May 3, 2012, at 11:15 a.m., revealed, "Called to dining room...had fallen...sitting in a chair and rocking, then...was found in the floor (with) a 4 cm (centimeter) lump on (resident) R (right) forehead. Moves all ext (extremities) well...Bruising noted (with) no other injuries apparent at this time." Medical record review of the nurse's notes dated May 3, through May 5, 2012, revealed the facility implemented interventions for the fall but no documentation of a complete skin assessment and no documentation of any injuries other than a bruise to the right forehead. Observation of the resident on May 8, 2012, at 8:03 a.m., in the resident's room, revealed a bruise on the right side of the resident's forehead and a large bruise on the resident's right lower leg. Interview on May 8, 2012, at 1:35 p.m., with the resident's spouse, in the resident's room, revealed the spouse confirmed the bruise to the resident's right lower leg occurred during the fall on May 3, 2012. Observation with Licensed Practical Nurse (LPN) #3 on May 8, 2012, at 1:40 p.m., in the resident's room, confirmed the resident had a large bruise with a raised knot on the resident's lower right leg. Interview with LPN #3 on May 8, 2012, at 1:45 p.m., at the nurse's station revealed, "Looks like	F 281	All residents have the potential to be affected. • All licensed nurses will be in-serviced on the Fall Management Program Policy with emphasis on proper documentation of fall and post fall assessments. • A licensed nurse will perform a full nursing assessment within 15 minutes of a fall (including vital signs, neurochecks, FSBS level if diabetic, active & passive ROM, skin status and pain status. • A licensed nurse will assess/document the residents neuro status, musculoskeltal status, pain and skin status every 8 hours x 48 hours following the fall occurrence. • Nursing Team Leader/RN Staff Nurse will audit nurses notes on all falls that occur to make sure the Post Fall Assessment documentation is inplace and report to the Quality Assurance Committee quarterly.	6/28/12

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F 281	Continued From page 3 an old bruise and probably didn't catch it." Continued interview confirmed "I was not told of bruise and normally don't check (resident) legs." Review of the facility's Falls Management Program Policy, revised April, 2010, revealed, "A licensed nurse will assess the resident's neuro (neurological) status, musculoskeletal status, pain and skin status every 8 hours x (for) 48 hours following the fall occurrence. The nurse will notify the physician and family member/responsible party immediately of any change found at the time of the assessment." Interview with the Director of Nursing on May 9, 2012, at 8:35 a.m., at the nurse's station, confirmed "Head-to-toe assessment should be completed" after a fall and the facility's policy for assessment after a fall had not been followed.	F 281		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 371		

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F 371	Continued From page 4 failed to properly store foods, failed to maintain a sanitary environment, and failed to maintain foods at a safe temperature in the dietary department. The findings included: Observation and interview on May 7, 2012, at 10:11 a.m., with the Dietary Manager, in the dietary department, revealed measuring cups and scoops were stored in the bulk bins of sugar, flour and cornmeal. Interview at this time confirmed the measuring cups and scoops were improperly stored. Observation and interview on May 7, 2012, at 10:25 a.m., with the Dietary Manager, in the dietary department, revealed four employee drinking cups stored on a shelf above the three compartment sink and clean surface area. Interview at this time confirmed employee drinking cups were stored in the food preparation area for residents. Observation and interview on May 7, 2012, at 10:37 a.m., with the Dietary Manager, in the dietary department, revealed an oscillating floor fan with dried debris and heavy dust blowing onto clean dishes and food preparation areas. Interview at this time confirmed the fan was not on a cleaning schedule, was in need of cleaning, and was blowing into a clean food preparation area. Observation and interview on May 7, 2012, at 10:43 a.m., with the Dietary Manager, in the dietary department, revealed a pan of red beans in the reach-in refrigerator with an expiration date of May 6, 2012. Interview at this time confirmed	F 371	F371 -All Dietary employees will attend a mandatory in-service to review Policy and Procedure #F006 (Employee Guidelines Infection Control Practices). Dietary Team Leader(s) and Coordinator will check bins daily to ensure scoops are not present in the said bins. Inspections will not be scheduled but random during operation hours. A log will be maintained reflecting the date, time and findings of the audit for a period of 90 days. In the event a scoop is found in the said bins, the 90 day period will be extended from the date of infraction and will be maintained until 100% compliance is met. All Dietary employees will attend a mandatory in-service to review Policy and Procedure #F006 (Employee Guidelines Infection Control Practices). Dietary Team Leader(s) and Coordinator will be responsible to ensure all employee drink cups are placed in the designated area (diet office). Any beverage vessel found in violation of this policy will be discarded and corrective action will be taken against the employee to reinforce	6/28/12

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F 371	Continued From page 5 the red beans were available for resident use beyond the expiration date. Observation and interview on May 7, 2012, at 12:10 p.m., with the Dietary Manager in the nursing home back hall, revealed the temperature of milk on a food tray was 47.2 degrees Fahrenheit. Interview at this time confirmed the holding temperature of the milk was above the required temperature of 41 degrees Fahrenheit.	F 371	the severity of the drinking in the kitchen environment. All fans located in the department will be placed on a daily cleaning schedule. The cleanliness will be monitored by the Team Leader(s) and Coordinator. A log will be maintained for a period of 90 days reflecting the visual inspection of the fan for cleanliness along with the name of the person that performed the cleaning task. *** F371 Continued on Next Separate Page *** **F431** A 1:1 discussion regarding appropriate storage/security of medications was conducted with RN #3 on May 8, 2012 by the Director of Nursing. The discussion included the LPN's/RN's must carry the keys on their person at all times. Personnel leaving the keys on the Medication/Narcotics cart or leaving the Medication/Narcotics carts unlocked while unattended will be subject to disciplinary action. • The Director of Nurses and Nursing Team Leader will conduct mandatory in-services for all licensed nurses on proper Drug Storage & Narcotic Areas. • Provide employee counseling/disciplinary action as indicated for non-compliance. • Random observation of medication carts will be	6/28/12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		

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F371 Continued:

All Dietary employees will attend a mandatory in-service to review Policy #B006 (Production, Purchasing, Storage).

Dietary Team Leaders(s) and Coordinator will check refrigerated areas daily to ensure food has not exceeded the expiration date guidelines. Inspections will not be scheduled but random during operation hours. A log will be maintained reflecting the date, time and finding of the audit for a period of 90 days. In the event an expired item is found in a specific unit, the 90 day period will be extended from the date of infraction and will be maintained until 100% compliance is met. Each refrigerated unit will be inspected independently daily with 100% of product inspected per unit.

Observation as related to milk temperature

All milk product will be temperature tested along with other food prior to tray line service. Milk will be covered with frozen custom fit surface placed within the cold tray compartment of the food container for transport. Milk temperature will be monitored upon arrival at the facility by testing an un-opened carton of milk held within the transport container label as "Test Tray". This will be the last tray to be

removed from the cart thus having the greatest potential for temperature abuse.
Monitoring of the milk temperature will be conducted daily during various meal periods. A milk temperature log will be maintained for a period of 90 days reflecting the date, time, person who took measurement and product temperature. In the event temperature abuse is found, the milk will be monitored for an additional 90 days until 100% compliance is met.

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F 431	Continued From page 6 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, the facility failed to maintain direct observation and security of the medication cart during the medication pass for one of two medications carts observed. The findings included: Observation on May 8, 2012, at 8:15 a.m., in the hallway, revealed Registered Nurse (RN) #3, during the medication pass, was preparing to administer medications for resident A. Further observation revealed prior to entering the room, the nurse left the narcotic keys lying on the top of the medication cart and did not lock the cart prior to entering the resident's room. Continued observation revealed the medication cart was not within direct observation by the licensed personnel and was left unattended. Further review revealed the medication cart contained multiple medications including Hydrocodone, Xanax, and Ativan. Interview with RN #3, on May 8, 2012, at 8:20 a.m., in the hallway outside of the resident's room, confirmed the narcotic keys were lying on the top of the medication cart and the cart was	F 431	observed monthly for security and reported to the Quality assurance Committee quarterly.	

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F 431	Continued From page 7 unlocked. Further interview with RN #3 confirmed the cart was left unattended. Review of facility policy # 10-018, Storage of Medications, with a revision date of October 2006, revealed "...all medications and other drugs, including treatment items shall be stored in a locked cabinet or room, inaccessible to residents and visitors...Medications shall be accessible only to personnel designated in writing by the facility's Resident Care Policies..." Interview with the Assistant Director of Nursing (ADON), on May 8, 2012, at 8:20 a.m., in the hallway outside of resident A's room, confirmed the narcotic keys lying on top of the medication cart and the cart was left unlocked, unattended and the cart was unsecured.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		

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F 441	Continued From page 8 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to follow Infection Control standards during incontinence and catheter care for one resident (#3) of four residents observed for incontinence care. The findings included: Resident #3 was admitted on July 12, 2011, with diagnoses including Hypertension, Depression, Peripheral Vascular Disease, Urinary Tract Infections, Quadriplegia, Neurogenic Bladder, and Anemia. Observation on May 8, 2012, at 9:45 a.m., in the resident's room, revealed Certified Nursing	F 441		

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F 441	Continued From page 9 Assistant (CNA) #1 and CNA #2 performed incontinence care and catheter care on resident #3. During care the resident had an involuntary bowel movement. Continued observation revealed CNA #1 and CNA #2 cleaned stool from the resident and, without changing gloves, manipulated the clean catheter with soiled gloves. Continued observation revealed CNA #1 and CNA #2 touched the resident's pillow, clothing, and bed sheets without changing the gloves. Further observation on May 8, 2012, at 10:15 a.m., revealed CNA #1 and CNA #2 returned to the resident's room to perform incontinence care and catheter care and the resident was incontinent of stool. Continued observation revealed CNA #1 and CNA #2 cleaned the resident of stool and proceeded to perform incontinence care and catheter care without changing the gloves. After providing catheter care CNA #1 and CNA #2 applied clean sheets and pillow cases to the resident's bed and repositioned the resident without changing gloves. Review of facility policy, Catheter Care, policy #11-083, last reviewed August 21, 2011, revealed, "...Note: Do not contaminate area with feces. If resident had an involuntary bowel movement, clean this area first. Wash your hands and obtain clean equipment for catheter care..." Interviews with CNA #1 and CNA #2 on May 8, 2012, at 10:30 a.m., in the staff lounge, confirmed staff had not changed soiled gloves between dirty and clean procedures as required by policy and procedure.	F 441	A 1:1 discussion regarding proper hand hygiene, incontinent care, and catheter care to Resident #3 was conducted with C.N.A #1 and C.N.A #2 on May 8, 2012 by the Director of Nurses. All residents have the potential to be affected. • All C.N.A's will be in-serviced on the importance of hand hygiene, incontinence care & foley care. • The Nursing Team Leader will monitor hand hygiene, (10 nursing staff members per month) and report results to the Quality Assurance Committee quarterly. Audit will focus on the nursing assistants providing incontinent care and foley care.	6/28/12

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F 441	Continued From page 10 Interview on May 8, 2012, at 10:40 a.m., with the Director of Nursing (DON), outside the DON's office, confirmed infection control practices had not been followed.	F 441		

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